STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		155662	A. BUILDING B. WING			03/02/2	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				IS R BOWEN DRIVE		
NURSING	G CARE AT HARTS	FIELD VILLAGE		MUNS ⁻	TER, IN46321		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
		,	17.00		`	-f	DATE
K0000	_	Code Recertification	K00	000	Preparation and / or execution the plan of correction in general		
		nsure Survey was			or this corrective action in		
	conducted by t	the Indiana State			particular does not constitute a	an	
	Department of	Health in accordance			admission or agreement of Nursing Care at Hartsfield Villa	age	
	with 42 CFR 4	83.70(a).			of the facts alleged or conclus		
					set forth in this statement of		
	Survey Date:	03/02/11			deficiencies. The plan of correction and specific correct	ive	
	J				actions are prepaired and/or		
	Facility Numb	er: 010758			executed in compliance with State and Federal laws.lt is the	<u>-</u>	
	Provider Numl				intention of this facility that this		
	AIM Number:				plan of correction serves as th	е	
	7 thivi i validoci.	20022)330			facility's credible allegation of compliance with all regulatory		
	C	hand D. Cahada I :fa			compliance.		
	_	hard D. Schade, Life					
	Safety Code S	pecialist			0054 AND K0067	K	
	At this Life Sa	fety Code survey,					
		at Hartsfield Village					
	was found not	in compliance with					
		for Participation in					
	Medicare/Med	_					
		O(a), Life Safety from					
	•	000 edition of the					
	National Fire I						
		VFPA) 101, Life					
	`	LSC), Chapter 19,					
	`	,, 1					
	-	h Care Occupancies					
	and 410 IAC 1	0.2.					
					mm -		
LABORATOR	Y DIRECTOR'S OR PROV	TDER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EGDW21 Facility ID:

010758

If continuation sheet

PRINTED: 04/01/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155662		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 03/02/2011	
	PROVIDER OR SUPPLIER		STREET A 503 OT	ADDRESS, CITY, STATE, ZIP CODE IS R BOWEN DRIVE TER, IN46321		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	basement was Type II (111) of fully sprinkler fire alarm syst detection in th sleeping room the corridors. capacity of 10 84 at the time Quality Review by Safety Code Special 03/09/11. The facility we compliance we aforementione					

010758

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING		COMPL	ETED
		155662	B. WING			03/02/2	011
			l		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			503 OT	IS R BOWEN DRIVE		
	G CARE AT HARTS				FER, IN46321		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION DATE
K0018	Based on obse	· · · · · · · · · · · · · · · · · · ·	K00		The employee break room doo	or	04/01/2011
			Koo	10	had a handset (positive latchin		04/01/2011
SS=E	<i>'</i>	facility failed to			device) installed on 3-8-11All		
		corridor doors to the			resident, staff, and visitors nea the employee break room had		
		k room would latch			potential to be affected by the		
	into the door f	rame or were			deicient practice. Becouse the		
	provided with	a device that exerts			deficient door has been repaire there is no more defective	ea,	
	at least 5 poun	ds of pressure to			practice.The employee break		
	keep the door	tightly closed. This			room door will be inspected monthly during the "MONTHLY	/	
	deficient pract	ice could effect all			MAINTENANCE INSPECTION		
	occupants in a	nd near the employee			CHECKLIST FOR COMMON		
	-	noke compartment			AREAS" form. It will be inspec to make sure that the employe		
	including staff	*			break room door will close and		
	residents.	, violitois alla			latch into the door frame.The		
	residents.				"MONTHLY MAINTENANCE INSPECTION CHECKLIST FO	ND.	
	Findings in slee	1			COMMON AREAS" form will b		
	Findings inclu	de:			brought to the Q.A. meeting fo		
	5 1 1				one year. Compliance will be reviewed during the meeting.		
		rvation on 03/02/11			Troviewed during the meeting.		
		with the maintenance					
	supervisor, the	e corridor door to the					
	employee brea	ık room was not					
	equipped with	a positive latching					
		ched into the door					
		ice to provide at least					
		pressure to keep the					
	_	The maintenance					
	_	nowledged at the					
		observation, the door did					
	not have positive latching device.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155662			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/02/2011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DRIVE MUNSTER, IN46321				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K0020 SS=E	Bused on coser varion and		K00)20	The #1 and #2 stair well doors from the secound floor were adjusted to close and latch int the frames. This was complete	o ed	04/01/2011
				on 3-4-11.All residents, staff, a visitors had the potential to be affected by the deficient praction. The doors will be inspected monthly durring the "MONTHI MAINTENANCE INSPECTION CHECKLIST FOR COMMON AREAS" form. The doors will inspected to make sure they close and latch properly. The "MONTHLY MAINTENANCE"	e ice. _Y N		
	on 03/02/11 w supervisor, the and # 2 from a not latch into t tested and did resistance ration maintenance s the time of obs				INSPECTION CHECKLIST FOR COMMON AREAS" form will be brought to the Q.A. commeteed quarterly for one year. Compliance will be reviewed during the meeting for tracking and trending. The #1, and #2 swell doors from the secound flawere repaired on 3-4-11.	e e g etair	

PRINTED: 04/01/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155662			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/02/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DRIVE MUNSTER, IN46321				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
K0027 SS=E	ensure 2 of 10 doors would re of smoke for a LSC, Section doors in smok comply with L LSC, Section in smoke barri opening leaving clearance necessions which inch to restrict smoke. This could affect re visitors in and compartments	ervation and facility failed to sets of smoke barrier estrict the movement at least 20 minutes. 19.3.7.6 requires e barriers shall LSC, Section 8.3.4. 8.3.4.1 requires doors fiers to close the ag only the minimum essary for proper ch is defined as 1/8 at the movement of deficient practice esidents, staff and near the smoke of the B wing, first ation and the A wing,	K0027	The smoke barrier doors for the 1st floor "B"-wing and the 2nd floor "A"-wing by the elevator were repaired on 3-4-11 by the maintenance department. The deficiency had the potential to affect all residents, staff, and visitors for the affected areas smoke barrier doors will be inspected monthly durring the "MONTHLY MAINTENANCE INSPECTION CHECKLIST FOR COMMON AREAS" forms. The smoke barrier doors will be checked to make sure the gain o larger than 1/8 inch. The "MONTHLY MAINTENANCE INSPECTION CHECKLIST FOR COMMON AREAS" form will be checked to make sure the gain olarger than 1/8 inch. The "MONTHLY MAINTENANCE INSPECTION CHECKLIST FOR COMMON AREAS" form will be brought to the Q.A. meeting quarterly for one year for tractand trending. The smoke barried doors for the 1st floor "B"-win and the 2nd floor "A"-wing by elevator were repaired on 3-4	e control of the cont	04/01/2011	
	Findings inclu	ide:					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

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If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155662		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 03/02/2011	
	PROVIDER OR SUPPLIER	FIELD VILLAGE	503 OT	ADDRESS, CITY, STATE, ZIP CODE IS R BOWEN DRIVE ER, IN46321	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	maintenance s 11:15 p.m. and 03/02/11, the s doors near the station on B w gap and the A barrier doors of had a 1/2 inch half of the door the times of of maintenance s	set of smoke barrier first floor nurses ring had a 1/2 inch wing set of smoke on the second floor gap near the bottom ors when closed. At oservation, the upervisor the gaps between the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155662	A. BUII B. WIN			03/02/2	011
NAME OF F	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE IS R BOWEN DRIVE		
NURSIN	G CARE AT HARTS	FIELD VILLAGE		MUNST	ΓER, IN46321		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K0029 SS=E	ensure 2 of 6 s serving hazard latched to previous smoke. This do could affect restaff in and neareas. Findings inclusion Based on observation of the second supplemental supplemental second floor sec	facility failed to oiled utility doors ous areas closed and rent the passage of deficient practice sidents, visitors and ar the hazardous de: rvations with the upervisor on een 11:40 a.m. and doors to the ms containing ies and soiled A wing first and oiled utility storage automatically close e storage rooms es, equipment, carts arrels. The upervisor the problem areas at	K00)29	The doors to the soild utility rooms for the 1A, and 2A units have been adjusted to close a latch into the frames. This was completed by the maintenance department on 3-4-11. All the residents, staff, and visitors in affected areas had the potentiat to be affected by the deficient practice. The soiled utility room doors will be checked monthly durring the "MONTHLY MAINTENANCE INSPECTION CHECKLIST FOR COMMON AREAS" forms. The soiled utilit room doors will be checked to close and latch into the frames. The "MONTHLY MAINTENANCE INSPECTION CHECKLIST FOR COMMON AREAS" forms will be brought the Q.A. commetee quarterly fone year for tracking and trending. The soiled utility room doors for the 1A, and 2A units were repaired on 3-4-11.	nd the al tity to for	04/01/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155662			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	1	E SURVEY PLETED /2011
	PROVIDER OR SUPPLIER	FIELD VILLAGE	503 OT	ADDRESS, CITY, STATE, ZIP COD TIS R BOWEN DRIVE TER, IN46321	E .	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155662		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED 03/02/2011			
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				IS R BOWEN DRIVE		
	G CARE AT HARTS				ΓER, IN46321		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
K0051	Based on obse	· · · · · · · · · · · · · · · · · · ·	K00		The items that were blocking to	he	04/01/2011
			IXOU	,51	access to the fire alarm pull		04/01/2011
SS=D		facility failed to			station were removed on 3-7-1	11	
		ire alarm pull stations			by the maintenance department. This deficiency ha	d	
	in the basemen	nt corridor near the			the potential to affect all staff in		
	elevator was re	eadily available. LSC			the basement area. The		
	9.6.2.6 require	s a manual pull			basement area is not a resider		
	_	nobstructed and			area. The items were removed 3-7-11, and no other items will		
		nis deficient practice			stored in this area.A sign will b	e	
		f in the facility's			placed on the wall of the affect		
		in the facility s			area that will read "NO ITEMS ARE TO STORED IN THIS		
	basement.				AREA". All current employees		
					that have responsibilities in the		
	Findings inclu	de:			basement will be educated on		
					need to keep this area clear. T maintenance director will moni		
	Based on obse	rvation on 03/02/11			the area for compliance Monda		
		uring a tour with the			through Friday and sign a		
	_	upervisor, the fire			compliance sheet for sixty day	S.	
		-			The compliance sheet will be located on the wall of the affect	ted	
	_	ion located in the			area.The compliance report wi		
		the elevator was			be brought to the Q.A.committ		
	blocked from a	access by 53 stacking			quarterly for one year for track and trending. The area has been		
	chairs, eight de	esk drawers and a			cleared of the items that were	511	
	folding table.	The maintenance			blocking the fire alarm pull stat	tion	
	_	nowledged at the			on 3-7-11. The compliance		
	•	ation, the pull station			conformation sheet was poster on 3-17-11.	d	
		and not accessible.			011 3-17-11.		
	was obstructed	i and not accessible.					
	3.1-19(b)						
	5.1 17(0)						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155662	B. WIN			03/02/2	011
NURSIN	PROVIDER OR SUPPLIER	FIELD VILLAGE		503 OT MUNST	ADDRESS, CITY, STATE, ZIP CODE TIS R BOWEN DRIVE FER, IN46321		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K0054 SS=E	ensure 6 of 18 the facility we flow would no their operation the provisions basic functions alarm system. requires fire all with NFPA 72 Code. NFPA 72 spaces served systems, detectlocated where operation of the deficient pract residents in an corridor smoke staff and visitor. Findings inclusible Based on obsemaintenance staff and signal of the control of the corridor smoke staff and visitor. Findings inclusible Based on obsemaintenance staff and visitor.	facility failed to 8 smoke detectors in re installed where air t adversely affect. LSC 9.6.1.3 says of 9.6 cover the s of a complete fire Section 9.6.1.4 arm systems comply, National Fire Alarm 72, 2-3.5.1 requires in by air handling tors shall not be air flow prevents be detectors. This ice could effect d near each of the e detectors, including ors.	K00	054	Because of the time that has elapsed from the original surve date, the April 1, 2011 deadling not feasible. The vender is scheduled to begin moving the affected smoke detectors on A 1, 2011, and the job completed April 8, 2011. The hall smoke detectors near the resident room B202, D201, C102, C108, B10 and the A-wing first floor living room will be moved so the air will not affect the operation of smoke detectors. All of the facinalls and lounge areas were inspected on March 10, 2011 the placement of the smoke detectors. All the smoke detectors in the halls and loun areas will be located so the air flow will not prevent operation the smoke detectors. The venous scheduled to begin moving affected smoke detectors on A 1, 2011. The job will be completeed by April 8, 2011.	e is e spril d by oms 02, flow the lity for ge of ler the	04/08/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155662			LDING	NSTRUCTION	(X3) DATE COMPI 03/02/2	ETED
	PROVIDER OR SUPPLIER		 STREET A	DDRESS, CITY, STATE, ZIP CODE IS R BOWEN DRIVE ER, IN46321	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	and the A wing room were loc of an air suppl	g first floor living ated within two feet y duct. This was by the maintenance he time of the				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION		A. BUILDING			COMPL	
		155662	B. WING			03/02/2	011
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
NI IDCINI	G CARE AT HARTS	EIELD VIII LACE			IS R BOWEN DRIVE		
					ER, IN46321		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
K0056	Based on obse	rvation and	K00	56	The sprinkler gauges for the #		04/01/2011
SS=E	interview, the	facility failed to			stair well on the second floor, a the #4 stair well on the first floor		
	· ·	prinkler gauges were			were replaced by McDaniel Fir	e e	
	tested every fir	ve years. NFPA 25,			Systems on 3-8-11. It was also determined that another gauge		
	-	states gauges shall be			the basement fire pump room		
		five years or tested			needed replaced. This was als corrected on 3-8-11 by McDan		
	-	rs by comparison			Fire Systems. All of the sprinkl	er	
	with a calibrat	ed gauge. This			guages have the date they we		
	deficient pract	ice could affect all			replaced written on the face.Al residents, staff, and visitors, in		
	residents, staff	and visitors.			the facility had the potential to		
	Findings include:				affected by the deficiency. McDaniel Fire Systems will be reminded of the requirement that the	ne	
	Based on obse maintenance so 03/02/11 betwoeld 3:00 p.m., the # 4 stairwell or floor had no old gauge to show replaced or recovering first floor gauge was date maintenance so the time of observalize the springer.	rvation with the upervisor on een 11:25 a.m. and sprinkler gauge in the n D wing, second beervable date on the when it had been calibrated. The D r stairwell sprinkler	the the er t not		requirement that the sprinkler gauges be replaced every five years. And that this addressed on the documents submitted for the quarterly testing. The facility maintenant director will review the quarter documents for the sprinkler testing and confirm that the sprinkler system gauges were checked. Reports of compliant will be brought to the Q.A. committee quarterly for trackin and trending. The guages for the sprinkler system were replaced on 3-8-11.	ce ly ce g ne	

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/02/2011	
NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE			503 O	ADDRESS, CITY, STATE, ZIP CODE TIS R BOWEN DRIVE TER, IN46321		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODE TAG		(X5) COMPLETION DATE	
K0062 SS=E	Based on obse interview, the ensure a cleararinches was man sprinkler defle sprinklers in the cooler. NFPA unacceptable of patterns shall be NFPA 13, 1999 says a continuous obstruction less inches from the prevents the sprinklers affects the kitchen free. Finding include Based on obse	rvation and facility failed to ance of at least 18 intained from the ector for 2 of 2 he kitchen freezer and 25, 2-2.1.2 requires obstructions to spray be corrected. Further 9 edition, at 5-5.5.1 ous or noncontinuous as than or equal to 18 he sprinkler deflector oray pattern from hig. This deficient is staff in and near the ezer and cooler.	K0062	The light fixtures in the kitcher freezer and cooler were relocated and are no longer obstructing sprinkler heads. This was completed by an outside vend on 3-4-11. The freezer and cooler located inside the kitchen this is not a resident or visitor area. Only staff had the potent to be affected by the deficient practice. The deficient practice was corrected on 3-4-11. The light fixtures are securely mounted the ceilings of the freezer and cooler. There are no systemic changes needed to ensure the deficient practice may recur. The corrective action will not have need to be monitored. The light fixtures are securely mounted the ceilings of the freezer and cooler, and can not be moved accident.	on 04/01/2011 ated the er oler and tial eright to er the ent to	
	the maintenance	11 during a tour with ce supervisor, the s in the kitchen				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155662			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE: COMPLETED 03/02/2011			LETED	
NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DRIVE MUNSTER, IN46321				
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	by the light fix area. The mai stated at the ti	oler were obstructed ature in each storage intenance supervisor me of observations, aware of the problem.					

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
		IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
	155662		B. WING			03/02/20	11
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
NI IDQINI		EIELD VILLAGE		l	'IS R BOWEN DRIVE FER, IN46321		
	JRSING CARE AT HARTSFIELD VILLAGE				1 - 11, 11140321		77.0
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE	
K0067	Based on reco	rd review and	K006)67	Because of the amount of time	e 03/30/201	05/30/2011
SS=F	interview, the	facility failed to			and work needed to correct th deficiency, we feel we will not		
	ensure 24 of 2	4 dampers in the			able to have the deficiency		
	ductwork at sr	noke barriers were			corrected by April 1, 2011. Therefore we are submitting a		
	inspected and	provided necessary			time table with targeted dates,		
	maintenance a	t least every four			and a completion date for the damper inspections.a) Contact		
	years in accord	dance with NFPA			vender to locate and access a		
	90A. LSC 9.2	.1 requires air			fire dampers.b) Inspect and exercise all accessable fire		
	conditioning, l	heating, ventilating			dampers.c) Document all fire		
	ductwork and	related equipment			dampers that need more accessability to complete the inspection. Items labled a,b,and		
	shall be in acc	ordance with NFPA					
	90A, Standard	for the Installation	stallation c, have a target date of A		c, have a target date of April 1	1,	
	of Air-Conditi	Conditioning and Ventilating			2011.d) Determine the vender needed to make the	s	
	Systems. NFF	PA 90A, 1999 Edition,			unaccessable dampers		
	3.4.7, Mainten	ance, requires at least			accessable. (Construction, H\ ect.)e) Aquire quote for vende		
	every 4 years, fusible links shall be				Request funds for project.Item		
	removed; all d	ampers shall be			labeled d,e, and f have a targe		
	operated to ver	rify they fully close;			date of April 29, 2011.g) Order supplies needed for the project		
	the latch, if pro	ovided, shall be			Receive supplies and schedul	e	
		noving parts shall be			project. i) Complete project by May 30, 2011.		
	, , , , , , , , , , , , , , , , , , ,	necessary. This			ay 00, 2011.		
	deficient pract	•					
	residents, staff						
	,						
	Findings include:						
	Based on record review with the						
	maintenance s	upervisor on					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EGDW21 Facility ID: 010758

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155662		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION	(X3) DATE SURVEY COMPLETED 03/02/2011		
NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE			503 OT	ADDRESS, CITY, STATE, ZIP CODE IS R BOWEN DRIVE TER, IN46321	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
TAG	03/02/11 at 10 no evidence al ductwork had 12/20/06. Bas with the maint the time of recunable to providampers had required maint maintenance shad verified the	:35 a.m., there was 1 24 dampers in the been inspected since ed on an interview enance supervisor at ord review, he was ide evidence the eccived a current and ection and the tenance. The upervisor stated he te lack of a current th Tyco-Simplex, the	TAG	DEFICIENCY)		DATE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155662		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 02/02/2011		
		155002	B. WING			03/02/2011	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
NURSING CARE AT HARTSFIELD VILLAGE			503 OTIS R BOWEN DRIVE MUNSTER, IN46321				
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	(X5) COMPLETION	
TAG	` ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	E DATE	ION
K0144	Based on obse	ervation, record	K01	144	The vender was contacted for	0 1/01/20	011
SS=F	review and int	erview; the facility			quote to have the remote shut installed for the generator. The		
	failed to ensur	e 1 of 1 emergency			project is scheduled for March		
	generators was	s equipped with			2011. This deficiency has the potential to affect all residents		
	remote manua	l stops. LSC 7.9.2.3			staff, and visitors in the event	of	
	requires emerg	gency generators			an emergency. The remote sh off is scheduled for installation	I	
	providing pow	er to emergency			3-22-2011. When the remote s	hut	
	lighting systen	ns shall be installed,			off is installed on 3-22-11. It w be monitored by the generator	I	
	tested and mai	ntained in			panel. The panel will alarm if t	l l	
	accordance wi	th NFPA 110,			"stop switch" or the "remote stop	ор	
	Standard for E	Emergency and			switch" is not in the normal position.The generator		
	Standby Powe	r Systems. NFPA			remote enunciator pannel is		
	110, 1999 edit	ion, 3-5.5.6 requires			located at the first floor nurses station.		
	Level II install	lations shall have a					
	remote manua	l stop station of a					
	type similar to	a break-glass station					
	located elsewh	nere on the premises					
	where the prime mover is located outside the building. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998						
	Edition, at 8-2	.2(c) requires engines					
	of 100 horsepo	ower or more have					
	provision for t	he shutting down the					
	engine at the e	engine and from a					
	remote locatio	n. This deficient					
	practice could	affect all residents,					

	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
155662				03/02/2011			
			_	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER							
NURSING CARE AT HARTSFIELD VILLAGE			MUNST	ER, IN46321			
,							
	· · · · · · · · · · · · · · · · · · ·					DITE	
Findings inclu	de:						
Based on revie	ew of the Generator						
Maintenance re	ecords on 03/02/11 at						
10:20 a.m. with	h the maintenance						
supervisor, the	ere was no						
documentation available which indicated the amount of horsepower							
the generator n	notor provided.						
Based on obser	rvation of generator						
equipment on	03/02/11 at 3:15 p.m.						
during a tour o	of the facility with the						
maintenance su	upervisor, no						
evidence of a r	remote shut off						
device was fou	and for the generator,						
furthermore, th	ne maintenance						
supervisor indi	icated he was not						
sure if the gene	erator was 100						
horsepower or	more. The						
maintenance su	upervisor indicated						
he was not awa	are of a remote shut						
off device for t	the generator and						
thought the generator was installed before 2003.							
	SUMMARY S' (EACH DEFICIENCE REGULATORY OR STAFF and visitor emergency. Findings inclusion and the maintenance of the generator of the generat	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) staff and visitors in the event of an emergency. Findings include: Based on review of the Generator Maintenance records on 03/02/11 at 10:20 a.m. with the maintenance supervisor, there was no documentation available which indicated the amount of horsepower the generator motor provided. Based on observation of generator equipment on 03/02/11 at 3:15 p.m. during a tour of the facility with the maintenance supervisor, no evidence of a remote shut off device was found for the generator, furthermore, the maintenance supervisor indicated he was not sure if the generator was 100 horsepower or more. The maintenance supervisor indicated he was not aware of a remote shut off device for the generator and thought the generator was installed	CARE AT HARTSFIELD VILLAGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) staff and visitors in the event of an emergency. Findings include: Based on review of the Generator Maintenance records on 03/02/11 at 10:20 a.m. with the maintenance supervisor, there was no documentation available which indicated the amount of horsepower the generator motor provided. Based on observation of generator equipment on 03/02/11 at 3:15 p.m. during a tour of the facility with the maintenance supervisor, no evidence of a remote shut off device was found for the generator, furthermore, the maintenance supervisor indicated he was not sure if the generator was 100 horsepower or more. The maintenance supervisor indicated he was not aware of a remote shut off device for the generator was installed	CARE AT HARTSFIELD VILLAGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Staff and visitors in the event of an emergency. Findings include: Based on review of the Generator Maintenance records on 03/02/11 at 10:20 a.m. with the maintenance supervisor, there was no documentation available which indicated the amount of horsepower the generator motor provided. Based on observation of generator equipment on 03/02/11 at 3:15 p.m. during a tour of the facility with the maintenance supervisor, no evidence of a remote shut off device was found for the generator, furthermore, the maintenance supervisor indicated he was not sure if the generator was 100 horsepower or more. The maintenance supervisor indicated he was not aware of a remote shut off device for the generator and thought the generator was installed	OVIDER OR SUPPLIER CARE AT HARTSFIELD VILLAGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) staff and visitors in the event of an emergency. Findings include: Based on review of the Generator Maintenance records on 03/02/11 at 10:20 a.m. with the maintenance supervisor, there was no documentation available which indicated the amount of horsepower the generator motor provided. Based on observation of generator equipment on 03/02/11 at 3:15 p.m. during a tour of the facility with the maintenance supervisor, no evidence of a remote shut off device was found for the generator, furthermore, the maintenance supervisor indicated he was not sure if the generator was 100 horsepower or more. The maintenance supervisor indicated he was not aware of a remote shut off device for the generator and thought the generator was installed	OVIDER OR SUPPLIER CARE AT HARTSFIELD VILLAGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) STATE THAT HAPTORY OR LSC IDENTIFYING INFORMATION) STATE THAT HAPTORY OR LSC IDENTIFYING INFORMATION) STATE THAT HAPTORY OR LSC IDENTIFYING INFORMATION) FROM THAT HAPTORY OR LSC IDENTIFYING INFORMATION STATE THAT HAPTORY OR LSC IDENTIFYING INFORMATION TAG PROPERTY ABOVED SA REFERENCE TO THE APPROPRIATE CROSS-REFERENCE TO THE APPROPRIATE TAG PROVIDE OF THE APPROPRIATE TAG PROVIDE OF THE APPROPRIATE CROSS-REFERENCE TO THE APPROPRIATE TAG PROVIDE OF THE APPROPRIATE TAG PROV	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155662		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED 03/02/2011			LETED		
NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DRIVE MUNSTER, IN46321				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
	3.1-19(b)						

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